

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155656		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2011	
NAME OF PROVIDER OR SUPPLIER CANTERBURY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000	<p>This visit was for the Investigation of Complaint IN00095525.</p> <p>Complaint IN00095525 - Substantiated. Federal/state deficiency related to the allegation is cited at F-253.</p> <p>Survey dates: August 31 & September 1, 2011</p> <p>Facility number: 000275 Provider number: 155656 AIM number: 100290930</p> <p>Survey team: Angela Strass, RN TC Sue Brooker, RD (August 31, 2011) Rick Blain, RN</p> <p>Census bed type: SNF/NF: 110 Total: 110</p> <p>Census payor type: Medicare: 13 Medicaid: 76 Other: 21 Total: 110</p> <p>Sample: 6</p> <p>This deficiency also reflects state findings</p>			F0000	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This Plan of Correction is being prepared and/or executed solely because it is required by the provision of federal and state law. We respectfully request that this Plan of Correction serve as our allegation of compliance, effective September 9, 2011 and request that this plan be considered for a desk review since there was no actual harm.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F0253 SS=E	<p>cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 9/2/11 by Jennie Bartelt, RN.</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to ensure 1 of 5 dining rooms observed for cleanliness was free from mold, affecting 7 of 7 residents during random observation of residents having lunch in the restorative dining room .</p> <p>Findings include:</p> <p>A tour of the facility was conducted with the Maintenance Director and Housekeeping Supervisor on 8/31/2011 at 10:15 A.M. During the tour, the west wall of the restorative dining room was observed to have loose, torn wall paper along the bottom of the wall above the baseboard. On the wall next to the exterior door of the dining room, a black powdery substance was observed on the exposed surface of the wallboard. At that time, during an interview with the Maintenance Director, he indicated the black substance was mold. He further indicated there had previously been a</p>			F0253	<p>It is the policy of this facility to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. (1) (Corrective action for alleged deficient practice:) The wall paper in the restorative dining room was removed and the walls were treated for black powdery substance. The walls were cleaned and painted. See attachment A: Supply receipts (2) (Identification of other residents that have potential to be affected by alleged deficient practice:) Maintenance conducted observation rounds in each of the dining rooms where residents eat meals. No other areas were identified to show black powdery substance. See attachment B: Observation Round Form. (3) (Systematic change to ensure alleged deficient practice does not recur:) Hsling staff will be responsible to observe and identify for any signs of black powdery substance during their daily cleaning of the dining rooms and resident rooms. A maintenance repair slip will be</p>		09/09/2011

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	<p>problem with excess moisture along the wall due to a drainage problem in the courtyard and water from the roof.</p> <p>The Director of Nursing (DON) was interviewed on 8/31/11 at 11:00 A.M. During the interview, the DON indicated there were seven residents in the restorative dining program who ate their meals in the restorative dining room.</p> <p>On 8/31/11 at 12:05 P.M., seven residents were observed to be eating lunch in the restorative dining room.</p> <p>This federal tag relates to Complaint IN00095525.</p> <p>3.1-19(f)</p>				<p>turned in to the maintenance director for any areas that are found. The Maintenance Director will be responsible to ensure that any identified areas are immediately addressed. Hsling staff was inserviced of new system change. See attachment C: Inservice Record. (4) (How system will be monitored to ensure that alleged deficient practice does not recur:) The Maintenance Director will make wklly rounds in dining rooms for 30 days and then monthly thereafter, on-going. Any identified issues will be addressed immediately and resolved. The Administrator will complete monthly rounds on-going with the Maintenance Director to ensure that wall paper is in tact and that all resident areas are free from black powdery susbstance. These rounds will be reviewed during monthly CQI for 3 months, which thereafter on a as needed basis. See attachment D: CQI maintenance tool)</p>		